FOR INFORMATION, URGENT REQUESTS, AND RESULTS CALL (213) 226-7388 OR (213) 226-2863

I. Date of EEG Request: Age: Sex:

II. Routine Urgent (Call Urgent EEG's to EEG Laboratory)

III. Type of Procedure:

___ EEG With Hyperventilation And Photic Stimulation
___ EEG With Prolonged Temporal Recording
___ Narcolepsy Evaluation (Multiple Sleep Latency Test)
___ EEG, No Hyperventilation (See Section XIII, Below)
___ Sleep Deprived EEG
___ EEG: Brain Death Evaluation

IV. What are the primary questions you wish this procedure to address (Please provide - very important)

V. Relevant History (Include date of last seizure, if any):

VI. Chief Complaint/Diagnosis This Admission:

VII. Description of Seizure (If Any):

VIII. Other Major Medical Problems (List):

IX. Medications:

X. Potentially Infectious Patient? Yes No If Yes, Explain:

XI. Does Patient Require Any Special Equipment? (Restraints, Respirator, Infusion Pump, Other) No Yes

XII. Patient Status: Ambulatory Yes No Cooperative: Yes No If No, Explain

XIII. Contraindications To Hyperventilation:

			CNS:			CARDIAC:		
Asthma	Y	N	Acute Stroke	Y	N	Angina	Y	N
Pregnancy	Y	N	Aneurysm	Y	N	Arrhythmia	Y	N
Sickle Cell Anemia	Y	N	AVM	Y	N	Hypotension	Y	N
			CNS Mass	Y	N	Recent MI	Y	N
METABOLIC:			Increased ICP	Y	N	Uncontrolled HTN	Y	N
Hypoglycemia	Y	N						
On dialysis	Y	N	Other:					

XIV. Requesting Physician (Print): Signature:

Beeper Number/Extension: Name of Neurology Consult (If any):

Ward Senior (If patient is on Neurology Service)

OUTPATIENT ADDRESS: PHONE NUMBER:

INPATIENT CARE PLEASE ADDRESS LABEL

ELECTROENCEPHALOGRAM REQUEST

(Must be filled out completely and legibly)